

**AMENDMENT IN THE NATURE OF A SUBSTITUTE  
TO H.R. 2023**

**OFFERED BY M**\_\_.

Strike all after the enacting clause and insert the following:

**1 SECTION 1. SHORT TITLE.**

2       This Act may be cited as the “Asthmatic School-  
3 children’s Treatment and Health Management Act of  
4 2003”.

**5 SEC. 2. FINDINGS.**

6       The Congress finds the following:

7           (1) Asthma is a chronic condition requiring life-  
8 time, ongoing medical intervention.

9           (2) In 1980, 6,700,000 Americans had asthma.

10          (3) In 2001, 20,300,000 Americans had asth-  
11 ma; 6,300,000 children under age 18 had asthma.

12          (4) The prevalence of asthma among African-  
13 American children was 40 percent greater than  
14 among Caucasian children, and more than 26 per-  
15 cent of all asthma deaths are in the African-Amer-  
16 ican population.

17          (5) In 2000, there were 1,800,000 asthma-re-  
18 lated visits to emergency departments (more than



1       728,000 of these involved children under 18 years of  
2       age).

3           (6) In 2000, there were 465,000 asthma-related  
4       hospitalizations (214,000 of these involved children  
5       under 18 years of age).

6           (7) In 2000, 4,487 people died from asthma,  
7       and of these 223 were children.

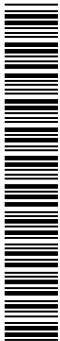
8           (8) Asthma is a common cause of missed school  
9       days, accounting for approximately 14,000,000  
10      missed school days annually.

11          (9) Working parents of children with asthma  
12      lose an estimated \$1,000,000,000 a year in produc-  
13      tivity.

14          (10) At least 18 States have legislation pro-  
15      tecting the rights of children to carry and self-ad-  
16      minister asthma metered-dose inhalers, and at least  
17      8 States expand this protection to epinephrine auto-  
18      injectors.

19          (11) Guidelines do not necessarily protect the  
20      rights of children in every school—tragic refusals of  
21      schools to permit students to carry their inhalers  
22      and auto-injectable epinephrine have occurred, some  
23      resulting in death and spawning litigation.

24          (12) Schools that restrict or revoke the rights  
25      of children to carry such inhalers and auto-injectable



1 epinephrine put themselves and students with asth-  
2 ma and severe allergic reactions, including anaphy-  
3 laxis, at risk of death. Such schools also put other  
4 students at risk of witnessing a potentially life-  
5 threatening asthma attack.

6 (13) School district medication policies must be  
7 developed with the safety of all students in mind.  
8 Easy access to and correct use of asthma inhalers  
9 are necessary to avoid serious respiratory complica-  
10 tions secondary to acute exacerbation and to im-  
11 prove the quality of life of students with asthma.

12 (14) No school should interfere with the pa-  
13 tient-physician relationship.

14 (15) Anaphylaxis, or anaphylactic shock, is a  
15 systemic allergic reaction that can kill within min-  
16 utes. Anaphylaxis occurs in some asthma patients.  
17 According to the American Academy of Allergy,  
18 Asthma, and Immunology, people who have experi-  
19 enced symptoms of anaphylaxis previously are at  
20 risk for subsequent reactions and should carry an  
21 epinephrine auto-injector with them at all times, if  
22 prescribed.

23 (16) Because asthma is a condition that often  
24 arises from allergies, it is critical to include anaphy-  
25 laxis in asthma treatment. Specifically, the res-



1       piratory problems that arise during an asthma at-  
2       tack usually occur because of a reaction to certain  
3       allergens, including dust, pollen, molds, and specific  
4       foods.

5           (17) An increasing number of students and  
6       school staff have life-threatening allergies. Exposure  
7       to the affecting allergen can trigger anaphylaxis. An-  
8       aphylaxis requires prompt medical intervention with  
9       an injection of epinephrine.

10          (18) Avoidance, early recognition, and prompt  
11       treatment are essential to the management of life-  
12       threatening allergies. There are students and school  
13       staff who have known life-threatening allergies, and  
14       those who have not been identified. Prompt interven-  
15       tion with epinephrine is vital to saving lives.

16   **SEC. 3. PREFERENCE FOR STATES THAT ALLOW STUDENTS**  
17                   **TO    SELF-ADMINISTER    MEDICATION    TO**  
18                   **TREAT ASTHMA AND ANAPHYLAXIS.**

19       Section 399L of the Public Health Service Act (42  
20   U.S.C. 280g) is amended—

21           (1) by redesignating subsection (d) as sub-  
22       section (e); and

23           (2) by inserting after subsection (c) the fol-  
24       lowing:



1 “(d) PREFERENCE FOR STATES THAT ALLOW STU-  
2 DENTS TO SELF-ADMINISTER MEDICATION TO TREAT  
3 ASTHMA AND ANAPHYLAXIS.—

4 “(1) PREFERENCE.—The Secretary, in making  
5 any grant under this section or any other grant that  
6 is asthma-related (as determined by the Secretary)  
7 to a State, shall give preference to any State that  
8 satisfies the following:

9 “(A) IN GENERAL.—The State must re-  
10 quire that each elementary school and sec-  
11 ondary school (whether public or nonpublic) in  
12 that State will grant to any student in the  
13 school an authorization for the self-administra-  
14 tion of medication to treat that student’s asth-  
15 ma or anaphylaxis, if—

16 “(i) a health care practitioner pre-  
17 scribed the medication for use by the stu-  
18 dent during school hours and instructed  
19 the student in the correct and responsible  
20 use of the medication;

21 “(ii) the student has demonstrated to  
22 the health care practitioner (or such prac-  
23 titioner’s designee) and the school nurse (if  
24 available) the skill level necessary to use  
25 the medication and any device that is nec-



1           essary to administer such medication as  
2           prescribed;

3           “(iii) the health care practitioner for-  
4           mulates a written treatment plan for man-  
5           aging asthma or anaphylaxis episodes of  
6           the student and for medication use by the  
7           student during school hours; and

8           “(iv) the student’s parent or guardian  
9           has completed and submitted to the school  
10          any written documentation required by the  
11          school, including the treatment plan for-  
12          mulated under clause (iii).

13          “(B) SCOPE.—An authorization granted  
14          under paragraph (1) must allow the student in-  
15          volved to possess and use his or her  
16          medication—

17               “(i) while in school;

18               “(ii) while at a school-sponsored activ-  
19               ity;

20               “(iii) during normal before-school and  
21               after-school activities, such as before-school  
22               or after-school care on school-operated  
23               property; and

24               “(iv) in transit to or from school or  
25               school-sponsored activities.



1                   “(C) DURATION OF AUTHORIZATION.—An  
2 authorization granted under paragraph (1)—

3                   “(i) must be effective only for the  
4 school year for which it is granted; and

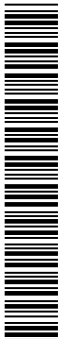
5                   “(ii) must be renewed by the parent  
6 or guardian each subsequent school year in  
7 accordance with this subsection.

8                   “(D) BACKUP MEDICATION.—The State  
9 must require that backup medication, if pro-  
10 vided by a student’s parent or guardian, be  
11 kept at a student’s school in a location easily  
12 accessible to the student in the event of an  
13 asthma or anaphylaxis emergency.

14                   “(E) MAINTENANCE OF INFORMATION.—  
15 The State must require that information de-  
16 scribed in subparagraphs (A)(iii) and (A)(iv) be  
17 kept on file at the student’s school in a location  
18 easily accessible in the event of an asthma or  
19 anaphylaxis emergency.

20                   “(2) RULE OF CONSTRUCTION.—Nothing in  
21 this subsection creates a cause of action or in any  
22 other way increases or diminishes the liability of any  
23 person under any other law.

24                   “(3) DEFINITIONS.—For purposes of this sub-  
25 section:



1           “(A) The terms ‘elementary school’ and  
2           ‘secondary school’ have the meaning given to  
3           those terms in section 9101 of the Elementary  
4           and Secondary Education Act of 1965.

5           “(B) The term ‘health care practitioner’  
6           means a person authorized under law to pre-  
7           scribe drugs subject to section 503(b) of the  
8           Federal Food, Drug, and Cosmetic Act.

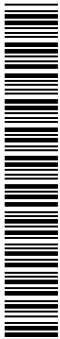
9           “(C) The term ‘medication’ means a drug  
10          as that term is defined in section 201 of the  
11          Federal Food, Drug, and Cosmetic Act and in-  
12          cludes inhaled bronchodilators and auto-  
13          injectable epinephrine.

14          “(E) The term ‘self-administration’ means  
15          a student’s discretionary use of his or her pre-  
16          scribed asthma or anaphylaxis medication, pur-  
17          suant to a prescription or written direction  
18          from a health care practitioner.”.

19   **SEC. 5. SENSE OF CONGRESS REGARDING CDC’S STRATE-**  
20                   **GIES FOR ADDRESSING ASTHMA WITHIN A**  
21                   **COORDINATED SCHOOL HEALTH PROGRAM.**

22          (a) FINDINGS.—The Congress finds as follows:

23                  (1) Possession and administration of medication  
24          is only 1 component of asthma and anaphylaxis  
25          management.





1           (2) The Centers for Disease Control and Pre-  
2           vention has identified 6 strategies for addressing  
3           asthma within a coordinated school health program.

4           These strategies consist of the following:

5                   (A) Establishing management and support  
6                   systems for asthma-friendly schools.

7                   (B) Providing appropriate school health  
8                   and mental health services for students with  
9                   asthma.

10                  (C) Providing asthma education and  
11                  awareness programs for students, school staff,  
12                  parents, and guardians.

13                  (D) Providing a safe and healthy school  
14                  environment to reduce asthma triggers.

15                  (E) Providing safe, enjoyable physical edu-  
16                  cation and activity opportunities for students  
17                  with asthma.

18                  (F) Coordinating school, family, and com-  
19                  munity efforts to better manage asthma symp-  
20                  toms and reduce school absences among stu-  
21                  dents with asthma.

22           (3) Providing appropriate school health and  
23           mental health services for students with asthma in-  
24           cludes the following:



1 (A) Obtaining a written asthma action  
2 plan for all students with asthma, which plan—

3 (i) should be developed by a primary  
4 care provider and provided by parents;

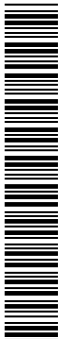
5 (ii) should include individualized  
6 emergency protocol, medications, peak flow  
7 monitoring, environmental triggers, and  
8 emergency contact information; and

9 (iii) should be effective only for the  
10 school year for which the plan is granted  
11 and must be renewed by the physician and  
12 parents or guardian of the student each  
13 subsequent school year.

14 (B) Sharing the plan with appropriate fac-  
15 ulty and staff in accordance with guidelines  
16 under section 444 of the General Education  
17 Provisions Act (20 U.S.C. 1232g; commonly re-  
18 ferred to as the “Family Educational Rights  
19 and Privacy Act of 1974”) or with parental  
20 permission.

21 (C) Ensuring that—

22 (i) at all times students have options  
23 for immediate access to medications, as  
24 prescribed by a physician and approved by  
25 parents; and



1 (ii) specific options, such as allowing  
2 students to self-carry and self-administer  
3 medications, are determined on a case-by-  
4 case basis with input from the physician,  
5 parent, and school.

6 (D) Using standard emergency protocols  
7 for students in respiratory distress if they do  
8 not have their own asthma action plan.

9 (E) Ensuring that case management is  
10 provided for students with frequent school ab-  
11 sences, school health office visits, emergency de-  
12 partment visits, or hospitalizations due to asth-  
13 ma.

14 (F) Providing a full-time registered nurse  
15 all day, every day for each school.

16 (G) Ensuring access to a consulting physi-  
17 cian for each school.

18 (H) Referring students without a primary  
19 care provider to child health insurance pro-  
20 grams and providers.

21 (I) Providing and coordinating school-  
22 based counseling, psychological, and social serv-  
23 ices for students with asthma, as appropriate.

24 (J) Coordinating with community services.



1       (b) EXPRESSION OF SUPPORT.—The Congress sup-  
2   ports the goals and ideals of the strategies identified by  
3   the Centers for Disease Control and Prevention for ad-  
4   dressing asthma within a coordinated school health pro-  
5   gram.

